Mental Health and Disability Services
Redesign 2011

MHDS Redesign ID/DD Workgroup Minutes

Meeting #2
September 6, 2011, 10:00 am to 3:00 pm
United Way Conference Center
1111 9th Street, Des Moines, IA

MINUTES

Attendance

Workgroup Members: Jim Aberg, Ron Askland, Bob Bacon (Co-chair), Mary Dubert, Marsha Edington-Bott, Dawn Francis, Stephanie Gehlhaar, Jan Heidemann, Terry Johnson, Cindy Kaestner, Karalyn Kuhns (Chair), Mia Peterson, Susan Seehase, Dale Todd

Legislative Representation: Dave Heaton, State Representative, House District 91 (Henry County) and House Chair of the Health and Human Services Appropriations Subcommittee; Jack Hatch, State Senator, District 33 (Polk County) and Co-chair of the Legislative Interim Committee on MHDS Redesign

Facilitators: Valerie Bradley, Human Services Research Institute (HRSI)

DHS Staff: Connie Fanselow, Jennifer Harbison, Deborah Johnson, Joanna Schroeder, Ken Tigges

Other Attendees:

Ronda Bennett	Iowa Department of Inspections and Appeals
Amy Campbell	multi-client lobbyist
Mark Crawford	no affiliation listed
Marcy Davis	Candeo
Hanna Degroot	Iowa State Association of Counties
Pat Deluhery	Parent/former legislator
Diane Diamond	DHS Targeted Case Management
Glenda Farrier	Cass Incorporated
John Hale	Iowa Caregivers Association
Sue Lerdahl	Legislative Services Agency
Michelle Moore	Harmony House
Susie Osby	Polk County Health Services
John Pollak	Legislative Services Agency
Ann Riley	Center for Disabilities and Development

J. Mark Roberts	Lutheran Services in Iowa
Carol Saddoris	Discovery Living
Rik Shannon	Iowa Developmental Disabilities Council
Carol Warren	Progress Industries
Casey Westhoff	The Arc of Iowa
Dion Williams	Systems Unlimited

Agenda

Agenda Topics:
- Introductory Remarks and Overview of Agenda
- Review of Information Requested
- Best Practices and Trends in Performance Measures and Outcome Assessment
- Group Discussion of Targeted Outcomes, Performance Measures, and Quality Management
- Next Steps
- Meeting Summary
- Public Comment

Key questions to be discussed:
- How do you judge the quality of ID/DD services?
- What outcomes do you value?
- Where would you get information about the performance of the system?
- What changes in the quality assurance/performance management of the system do you think are necessary?
- What types of information should be available to the public regarding the quality of services to people with ID/DD?
- What role should people with disabilities and family members play in measuring performance?
- What are the most important facets of performance that should be monitored?

INTRODUCTORY REMARKS AND OVERVIEW OF AGENDA

Review of Emerging Areas of Consensus from Meeting 1:

Eligibility Process should be:
- Simplified and standardized
- more coherent for families
- one process
- LOC determination should be simplified
- Explore broader diagnostic criteria beyond ID
- Look at CMS & DOJ guidelines

Meeting 2 Handouts:
- Meeting Agenda
- ID/DD National Wait List Data
- DD Relative to ID Diagnosis (NCI)
- What is a Supports Waiver?
- Children Identified as Entitled to Special Education
- Ill & Handicapped Waiver Services
- Overview of Community Based ICF/MR
- County Statistical Information on Persons with DD
- Habilitation Services
- NASDDDS Waiver Recommendations, 2000
- Best Practices in Performance Measurement and Outcome Assessment
- Iowa CMS Performance Measures
- National Core Indicators Annual Report 2009
- SAMHSA's National Outcome Measure Domains
- Iowa Olmstead Plan Principles and Goals

OVERVIEW OF INFORMATION REQUESTED:

National Waiting List Data:
- No one is collecting data on how long people stay on waiting lists.
- In 2009, the University of Minnesota estimated 122,000 people were waiting for residential services nationally.
- Other estimates range from 115000 to 240,000.
- Wait lists increased by over 44,000 from 2005 to 2009.
- Waiting lists are expected to grow as states "slow" their eligibility determination processes.
- Family and Individual needs for Disability Supports (FINDS) survey in 2010 showed one-third of parents or caregivers were on waiting lists for public services.
- Generally, necessary services and supports are hard to find and the situation is getting worse.
- There may be more than 1 million people with ID/DD waiting for services that may never come.
- States vary in eligibility criteria for public services.

National Core Indicator (NCI) 2009-10 developmental disability data shows:
- 11% sampled had autism diagnosis
  - 5.7% of those had no ID diagnosis
- 14.7% had a cerebral palsy diagnosis
  - 4.6% of those had no ID diagnosis
- 31% had an epilepsy/seizure/neurological disorder
  - 1.9% of those had no ID diagnosis

What is a Supports Waiver?
- A 1915(c) Medicaid HCBS waiver that complements a traditional comprehensive services waiver.
- Tends to have a much lower dollar cap.
- Significant flexibility in the service menu.
- Assumes there are also natural supports available such as unpaid family caregivers.
- In 2006, 17 states were operating 21 supports waivers.
- States have used them to divert people from more expensive residential services.
- Funding limits range from $5000 to $52,000 per beneficiary.

Children Identified for Special Education in Iowa:
- Special education students account for about 13% of total enrollment.
- Special education students comprise 9 to 12% of graduating classes.
- Specific diagnostic data is not available.
- For 2008-09, the graduation rate for all public school students was 88.7% and for students with an IEP it was 79.55%.

HCBS Ill and Handicapped Waiver:
- Group asked for estimate of people without ID being served.
- About 249 people out of 2,470 are identified with an Autism spectrum or Pervasive Developmental Disorder (PDD).
- Services most commonly utilized are respite, Consumer Directed Attendant Care (CDAC), homemaker, and Consumer Choice Option (CCO).
- Average annual cost about $10,000 per recipient.

Community Based ICFs/MR:
- Total served 2,059.
- 92% are age 18 or over.
- Average served per month is 1610.
    - Of those, 360 are identified as having autism or PDD.
- Average annual cost $100,000 per recipient.

People with developmental disabilities (not ID) served by county funding:
- 60 counties provide full access to services (same as for ID population).
- 6 counties provide partial access to services (two or more significant services).
- 30 counties provide mandated services only (Medicaid services, for which the county pays the non-federal share).
- 3 counties provide mandated only through exceptions to policy approved by the Board of Supervisors.

Types of services provided include:
- Administration/consultation/education (all 1,187 DD clients eligible)
- Case management (695 persons)
- Community Based Support Services (715 persons)
- Treatment/Therapeutic Services (155 persons)
- Vocational Services (529 persons)
- Residential Services (124 persons)
- Hospitalization/Commitment Services (47 persons)

No information available on specific diagnoses or functional level of DD clients.
Counties are spending about $7.3 million on the listed services.

Workgroup Comments:
- We should have a goal that people receive some kind of service(s) after a certain amount of time on a waiting list.
- Having a quality assessment and accurate diagnosis are critical to getting the right services.

Habilitation Services:
- 1915(i) Waiver – included as a state Medicaid plan service.
- Aimed at assisting clients with chronic mental illness in acquiring, retaining and improving self-help, social, and adaptive skills needed to live successfully in home and community-based settings.
- Potentially open to people with Autism Spectrum Disorders (ASD).
- Services include: case management, home-based habilitation, day habilitation, prevocational, and supported employment.
- 3,900 currently enrolled.

NASDDDS Waiver Recommendations:
- In 2000, Robin Cooper conducted a review of Iowa's 6 HCBS Waiver programs.
- It points out that there are people with DD being served on other waivers.
- Recommended then that eligibility criteria be expanded to include people with DD diagnostic criteria.
- Recommended considering consolidation of the waivers.
- Recommended making case management as independent from service provision as possible.
- Recommended removing service-specific and monthly caps and using aggregate annual cost management.
- Recommended consistently collecting consumer satisfaction information.

As a comparison to Iowa:

- California has an entitlement for DD services.
- Looking at how many people they are serving could give us an idea what the numbers in Iowa might be like.
- In Iowa, HCBS Waivers are currently serving 533 per 100,000 people and the amount being spent on people on the Waiver is relatively low.
- In California, they are serving about 620 per 100,000 people and some are only receiving case management services.

BEST PRACTICES AND TRENDS IN PERFORMANCE MEASURES AND OUTCOME ASSESSMENT

Why should we care about quality?
- Need to keep promises to the people being served.
- Ideology alone does not create a stable system of supports.
- Publicly funded services represent a large investment.
- Policy makers and the public want to know what the result is.
- Have to build in quality measures to make sure our intent is realized.

Where have we been?
- We have used prescriptive licensing and treatment standards.
- We have focused on process rather than outcomes.
- Criteria were mostly clinical, medical and behavioral.
- Clients have not always been engaged.
- Value was not given to the outcomes desired by people with disabilities.

Pressure for more systematic ways to measure progress:
- We have an increasingly complex system.
- We need a sophisticated process to understand how it is working.
- We have better, more useful technology.
- There is an interest in accountability for results.
- There have been changes at CMS and a huge expansion of the HCBS Waiver.

How is the shape of public systems changing?
- There is an increased reliance on data.
- A movement to more centralized service coordination.
- A change from one size fits all, to more individualized, person-centered services.
- More people are living in smaller settings and with families.
- Accountability and transparency are tremendously important.
- Performance information can be posted online and made widely available.
- The role of CMS has gotten bigger.

How we measure performance should mirror our values:
- Person-centered, individually crafted
- Self-direction and self-determination
- Freedom from harm and abuse – health, welfare and safety issues

- Independence and productivity – working, earning money
- Inclusion and community participation
- Family support

DHS Olmstead plan system outcomes (principles):
- Public awareness and inclusion
- Access to services and supports
- Individualized and person-centered
- Collaboration and partnership in building community capacity
- Workforce and organizational effectiveness
- Empowerment
- Active participation
- Accountability and results for providers
- Responsibility and accountability for government

Individual outcomes (National Core Indicators consumer survey):
- People have support to find and maintain community integrated employment.
- People have support to participate in everyday community activities.
- People make choices about their lives and are actively engaged in planning their own services and supports.
- People have authority and are supported to direct and manage their own services.
- People have friends and relationships.
- People are satisfied with the services and supports they receive.
- People are safe from abuse, neglect, and injury.
- People secure needed health services.
- Medications are managed effectively and appropriately.
- People are supported to maintain healthy habits.
- The system makes limited use of restraints of other restrictive practices.
- People receive the same respect and protections as others in the community.

NCI Family Outcomes:
- Family members have the information and support needed to plan for their services and supports.
- Family members determine the services and supports they receive, and the individuals or agencies who provide them.
- Family members get the services and supports they need.
- Family members use integrated community services and participate in everyday community activities.
- Families maintain connections with members not living at home.
- Family members receive adequate and satisfactory supports.
- Individual and family supports make a positive difference in the lives of families.

CMS (Centers for Medicare and Medicaid Services) is changing its expectations regarding 1915(c) Waivers:
- Waiver programs for people with DD account for about 75% of all waiver spending.
- There are over 100 (possibly close to 200) DD waivers in operation around the country.
- In 2006 there were about 480,000 people with DD receiving wavier services at an annual cost of about $40,000 each.
- Four times as many people receive waiver services than are served in ICFs/MR.

The GAO (U.S. Government Accountability Office) found problems with waiver services in 2003:
- There was no detailed guidance to states on quality assurance.
- States were providing only limited information about quality approaches.
- Quality issues were being identified.
- Waivers were not reviewed timely or sometimes at all.

The New CMS Approach:
- Shifted away from sampling or "snapshots in time."
- Based on state monitoring its own processes and procedures.
- Requiring states to submit evidence around six assurances.
- CMS reviews reports and assesses how effectively the state is monitoring its own performance and addressing the issues identified.

The Six Assurances – all states must assure:
- Eligibility (level of care) is determined in a valid, reliable, and equitable manner.
- Individual plans include services and supports that align with the individual's goals, strengths, and needs.
- Provider qualifications are regularly checked and monitored.
- Individual health and well being is maintained.
- Financial accountability is maintained.
- The Medicaid agency maintains administrative authority.

Iowa CMS Performance Measures (handout):
- The assurances and sub-assurances are set by CMS.
- The state sets CMS expectations and determines exactly how they will measure and report their performance.

Components of quality assurance/performance assessment:
- Need to look at system from a variety of points of view to really understand quality.
- Make the assessment process leaner and more meaningful.

HCBS Quality Framework:
- A way for states to think about their quality assurance process.
  - Do people have access?

- Is service planning and delivery person-centered?
- Do providers have the capacity and capabilities to meet the need?
- Are safeguards in place to protect people?
- Do people know their rights and responsibilities?
- Are people achieving the outcomes they desire?
- Are they satisfied with the services and supports they receive?
- Is the system performing as it should?

What does quality management involve?
How does the system use information about its own performance to make itself better?
- By developing quality goals or indicators.
- By using data to identify performance issues.
- By making recommendations for improvements.
- By reviewing progress toward achieving targets/goals.
- By reviewing outcomes and measures and identifying new ones.

Focus on evidence:
- Collect qualitative and quantitative data from a variety of sources to answer questions about how your system is doing.
- Analyze data and use information to remediate problems and improve services and supports.

Examples of evidence for performance measures:
- Incident reporting
- Service coordination monitoring
- Consumer surveys
- Complaint reports
- Mortality reports

Comparative analyses:
- Useful as a tool to focus attention on differences.
- Identify areas needing further review and analysis.
- Can target analysis to region, type of provider or service, living arrangement, population.
- Can combine with trend analyses to identify changes over time by region, type, etc.
- Can help you target resources, training and efforts for quality improvement.

National Core Indicators (NCI):
- NCI data has been collected since 1997.
- Can be used to compare your own state over time or your state with other states.
- Used to monitor performance.
- See National Core Indicators Annual Report (handout).

NCI Consumer quality outcomes:
- Feelings of loneliness by living arrangement.
- Friendships by living arrangement.
- Cancer screenings by living arrangement.
    - Shows the more structured the setting the better medical screenings.
- Choice of where and with whom to live.
    - Still not very good as a system about helping people make choices.
- Choice of jobs and activities.
    - Seem to do better with job choices than day programs.
- Choice of free time and spending.
- Use of psychotropic medications.
    - About 64% of people in community-based settings are on at least one.
    - Yet only about 40% have a mental health diagnosis.
    - Correlation between the use of psychotropic medications and obesity is statistically significant.
- Type of community jobs.

DHS Olmstead Plan Systems Outcomes:
- Consistent with the NCI consumer and family outcomes.
- Were developed by reviewing all the various redesign documents produced since the 1990s.
- Looked for trends and areas of consensus.
- Advisory and advocacy groups weighed in.
- Arrived at the nine principles that guide the transformed system.
- Individual and family outcomes are imbedded in the Plan.
- Can find more Olmstead Plan information and the foundational documents at: http://IowaMHDSPlan.org.

What structures and processes need to be in place to ensure that those outcomes we value are achieved?

GROUP DISCUSSION OF TARGETED OUTCOMES, PERFORMANCE MEASURES, AND QUALITY MANAGEMENT

DHS Olmstead plan system principles:
- Public awareness and inclusion
- Access to services and supports
- Individualized and person-centered
- Collaboration and partnership in building community capacity
- Workforce and organizational effectiveness
- Empowerment
- Active participation
- Accountability and results for providers
- Responsibility and accountability for government

Any other principles to add?

Other ways to hold the system accountable?

The system should:
- Be cost effective.
- Be streamlined.
- Be relevant.
- Be responsive in a timely fashion.
- Offer an array of community based options.
- Be able to measure outcomes and use data for quality improvement.
    - Different data is needed at different levels of the system.
- Provide people with disabilities and families with the information they need to make decisions.
- Be integrated – all measuring the same things to produce reliable data.
- Meet all the necessary requirements for all users who need to access the data.
- Provide data that is relevant to individuals.
- Aim the outcomes at the people who are being served.
- Not keep track of data just because we can.
- Focus on the needs of consumers and families.
- Be simple and manageable, using a limited number of indicators.
- Have indicators relevant to what we are trying to accomplish.
- Have easily recognizable outcomes.
- Have data/reporting system that works for smaller providers.
- Set parameters for administrative philosophy.
- Provide information you can do something with/useful data elements.

How do you know if individual outcomes are being met?

Need consensus around individual outcomes and how we know they are being met.

NCI Individual Outcomes:
- People have support to find and maintain community integrated employment.
- People have support to participate in everyday community activities.
- People make choices about their lives and are actively engaged in planning their own services and supports.
- People have authority and are supported to direct and manage their own services.
- People have friends and relationships.
- People are satisfied with the services and supports they receive.
- People are safe from abuse, neglect, and injury.
- People secure needed health services.
- Medications are managed effectively and appropriately.
- People are supported to maintain healthy habits.
- The system makes limited use of restraints of other restrictive practices.
- People receive the same respect and protections as others in the community.

Other recommended individual outcomes:
- People have self-determination.
- Information for consumers and families is easy to understand and uses people first language.
- People get the services and supports they need.
- People get accurate diagnosis/comprehensive assessment.
- People choose where and with whom to live.
- People have transportation needed to gain access to jobs and activities.
- People have the ability to participate in self-advocacy activities.

Recommended family outcomes:
- Flexible service budgets for families.
- Access to respite support.
- Family members get breaks when they need them.
- Families receive the supports they need to keep the family together.

Discussion:
- Waiting lists don't necessarily mean that people aren't getting services.
- They may be waiting for a particular or a preferred service but receiving others.
- The legislature wanted this workgroup process so that the people who really know the system and the needs can bring forward their recommendations for redesigning the system, rather than having the legislature do it.

Iowa needs an adequate consistent set of core services:
- Should core services across the waivers be the same?
- Should core services across service populations be the same?
- Need equality of access for all service populations.

What outcome measures are we already using in Iowa?
- IAC Chapter 77 lists required outcome measures for waiver programs.
- Need to look at them in light of today's discussion.
- Need to look at adult mental health group's proposed outcomes – there are parallels between recovery thinking and self-determination.
- Need to look at all sources and integrate them.
- Also look at SAMHSA's National Outcome Measure Domains (handout).

What is the current process Iowa has in place to find out if individual outcomes are being met? Where does that information now exist?
- Some comes from audits.
- We have a lot of data but have difficulty getting it into a unified report or useful form.
- It takes putting manpower into the system to get data back out.
- Provider records are one of the things reviewed by the state.
- Iowa Participant Experience Survey (IPES/DD) - representative sample is done across all waivers.
- PES has been modified with additional questions to use in Iowa.

- Information is tallied and used internally by IME.
- Can recommend that IPES data be made available to the public.
- The Waiver survey could also be used in an ICF/MR setting; we don't have consumer survey information from ICFs/MR.
- .A lot of agencies do consumer surveys of their own.
- All Targeted Case Managers collect outcome data.
- Only data from DHS TCM is aggregated – that is available.
- Need to have everyone collect the same data to be useful.
- We have some county information – it is not coordinated statewide.

How can we eliminate redundancy?
- Crosswalk the outcomes we think are important with what we are doing.
- Make a decision about the best place for this info to be collected in an organized way.
- Build an IT system – would CSN (County Services Network) work?
- Crosswalk outcomes with data collected – look at consistency, how to aggregate for reporting purposes.

Provider capabilities:
- What monitoring structures are in place now?
  o Waiver certification
  o IAC Chapter 24 certification
- Are they looking at individual outcomes?
- State has moved away from individual outcomes approach in surveying because of limited resources.
- The state is pushing providers to get national accreditation.
- State reviews for state-specific standards:
  - State reviewers would do audits for quality.
  - Establish policies and procedures for training.
  - DHS reviews complaints – focused reviews.
  - A quality check is done at least once every 5 years.
  - If State certified, every three years.

- TCM is able to get assessments done because they have a cap on the number of clients they serve. Service workers may have a much higher caseload and cannot do the same level of client contact – assessments/surveys may not be practical.

Recommendations about infrastructure for monitoring and analysis:

Good examples from other states:
- Louisiana has an information technology system that allows real time incident management tracking – makes it much less labor intensive and information is immediate.
- Pennsylvania uses people with disabilities and family members to go out and review programs – pays stipends.

- Putting hotlines into place for ease of reporting incidents.

Does information collected lead to people getting better services and outcomes?

Many separate systems exist – they not coordinated:
- Desk audits
- On site reviews
- A lot of measurements are made, but not brought together

Recommendation:
- Take a new look at provider monitoring.
- Look for inefficiencies and duplication.
- See if the kinds of things being measured are consistent with the outcomes we want.
- Information should be available and useful to the public.

How does our current incident management system work? Who investigates?
- For waiver services, there is an electronic system attached to a workflow process.
- ISU contractor is responsible for those reviews.
- Providers report on how they follow up.
- The system is about two and half years old.
- Still getting all providers to use it.
- Information has not yet been made available publicly.
- DIA (Dept. of Inspections and Appeals) has another system.
- Adult protective services and child protective services also get reports.
- Integration is a work in progress.

Recommendation:
- Increase the state's ability to track and trend information.
- Provide access to mortality data.
- We have a historically localized system.
- Move to thinking about things in a more aggregate way.

Ways of collecting outcome information for families?
- Many providers voluntarily do their own surveys internally.
- Something more standardized across providers would allow aggregation of family satisfaction information.

Should we identify "key" indicators that are central to values?
- For example, we don't now really aggregate data on competitive employment – if we say that is a system value, then that should be a key indicator that is measured and tracked.

We may be doing federal reporting already that could be utilized.

NEXT STEPS:

Information requested for next meeting:
- Tentative consolidation list of individual outcomes identified to review and prioritize
- Crosswalk outcomes with:
  - Waiver outcome measures in IAC Chapter 77
  - IPES tool and survey data
  - TCM survey questions/outcomes
- NCI crosswalk
- Summary of current sources of consumer survey information/outcome reporting

Iowa Olmstead Plan can be referenced at http://IowaMHDSplan.org for more detailed information on the principles.

NEXT MEETING:

The next ID/DD Workgroup is scheduled to meet on Tuesday, September 20 from 10:00 am to 3:15 pm at the United Way Conference Center, 1111 9th Street, Des Moines, IA.

Meeting 3 Agenda Topics:
- Best practice and trends in core services
- Core services key decision points
- Core services workgroup recommendations

MEETING SUMMARY:

Emerging Areas of Consensus:
- Iowa needs to establish system and individual and family outcomes and measure them with performance indicators.
- Outcomes measured must relate to system values.
- They must be closely aligned with the principles of the Iowa Olmstead Plan.
- National Core Indicators individual and family outcomes form a basis for Iowa ID/DD outcomes.
- A list of all NCI and proposed additional outcomes will be compiled for the workgroup members to review and prioritize.
- Outcomes need to be consistent and equitable across populations served.
- Coordination will be needed with proposed mental health outcomes, children's outcomes, etc.
- Redundancy should be eliminated and quality management should be streamlined.
- Information technology can be a useful tool in gathering and reporting data.
- We need to increase our ability to track and trend data.
- Quality/outcome information should be publicly available.
- Systems outcomes and methods must work for all sizes of providers.

PUBLIC COMMENT:

Comment:	Does each county having core services mean that each county will have them within their borders, or will have money to pay for them?
Legislator Response:	Every county should have the same set of core services. The State will begin buying out the counties' contribution over four years. The provider presence might be within the county or it might be accessed in another county.
Comment:	We can choose to do anything; it just takes time and money. There needs to be a clear understanding of the definition of waiting lists. Every county defines waiting lists differently. Some have no waiting list because people are approved for services, but the providers have waiting lists because they are not authorized by the county to start serving. People may also be clearly underserved, but they are no longer on a waiting list for services because they are receiving something. With respect to electronic documentation systems, some providers have already made very large investments in purchasing systems. If the state asked providers to all change to the same one, there will have to be some negotiation because they can't afford to simply abandon their recent investments. When I talk to families they say things like "without respite services my marriage would not stay together," "without respite services I could not keep my job," and, "without respite services I could never go to my other kids games and activities" – respite services are very much needed by families.
Comment:	System outcome is essential to having a system work together. Polk County has developed a scorecard for employment and residential community living that we would be willing to share. We incentivize providers with outcome measures that are very similar to the outcomes envisioned in the Olmstead Plan and we use the same systems outcomes for all service populations.
Comment:	From the provider perspective, things are very segmented. Funding and regulatory entities all need to be talking. If providers are better at doing business, their rates go down, yet responsibilities get added on that cannot be included in cost reporting. At last count I think there were 35 different entities we are accountable to in some way.

Comment: Getting staff is a real issue for community providers and a big part of that is the wage differential between home and community staff and State employees. Providers need the ability to pay staff at a better rate and provide better training and benefits for them.

Comment: Pleased to see legislative representation at this meeting. Would like to underscore a comment made by one of the workgroup members, "Don't collect information just because we can – keep the focus on what the individual wants and needs."

Comment: Legislative staff has tried to make sure they have a monitor at each of these meetings and also meet weekly to keep up with the progress of the workgroups. The process is set up for the workgroups to submit a preliminary report in October and follow it up with a final report in December. There will be an opportunity for people to continue to follow the progress of the recommendations throughout the legislative session.

Comment: There are opportunities around health care reform for technology and data collection, including HIT (Health Information Technology) grants. I hope someone is watching those opportunities.

DHS Response: IME (the Iowa Medicaid Enterprise) is aware of those opportunities and is working on those areas.

Comment: Counties like Polk have waiting lists for services that go beyond the mandated services because it's the right thing to do and is cost effective in the long run. When you look at the waiting list issue, don't punish counties for trying to do more than they have to do. Look at providing some flexibility in core services so counties can still go above and beyond if they identify better ways that are cost effective.

For more information:

Handouts and meeting information for each workgroup will be made available at:
http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.